GLOBAL MEDICAL ETHICS

Response to reviews of the *World Medical Association Medical Ethics Manual*

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There are many challenges to be met when writing an introductory treatise on an academic topic. The subject matter must be presented in a simple but not over-simplified manner. Enough theory must be included to ground the discussion of specific issues but not so much as to overwhelm or bore the readers. The text should be long enough to do justice to the subject matter but short enough to be readily accessible, especially for readers such as healthcare professionals, whose primary concerns lie elsewhere.

There are additional challenges in a relatively novel interdisciplinary field such as bioethics. The scope and methodology of bioethics are matters of great controversy, as are its relations with related subjects such as professionalism and human rights. The field is so broad that a single author cannot claim expertise on all topics. Rivalries between law and ethics and among medicine, other health professions, and disciplines such as philosophy complicate efforts to produce a broadly acceptable text. Finally, national and cultural differences pose major challenges to anyone trying to write for a truly international readership.

The difficulty of meeting all these challenges in producing the *WMA Medical Ethics Manual* provides ample opportunity for criticism, especially from bioethics experts. The three expert reviewers of the manual in this issue of the journal are remarkably restrained in pointing out its shortcomings.[1 2 3] I am grateful for both their positive evaluations and their constructive criticism. In what follows, I will respond to each of them in turn, focusing in particular on their suggestions as to how the Manual could have been improved.

Before addressing these suggestions, I wish to clarify a matter raised by Søren Holm, namely, to what degree the manual reflects the views of the WMA.[1] Anyone working in an organisation, whether governmental, professional or commercial, must be careful when authoring a publication to distinguish between his or her personal views and those of the organisation. Moreover, some organisations require multiple layers of approval before the employee is permitted to publish anything. The WMA Council displayed exemplary trust in the author of the manual by giving him complete authority to decide on the final text, as long as a proviso was added that it did not necessarily reflect the policies of the WMA, except where this is clearly and explicitly indicated. That said, Søren Holm is generally correct in his assumption that no part of the manual directly contradicts the policies of the WMA, although on some issues—for example, the absolute nature of medical confidentiality, inconsistencies between different WMA policies are pointed out.

Søren Holm proceeds to raise two important objections to my classification and definition of ''medical ethics''. I agree that the relation of medical ethics to bioethics, as I describe it, is ambiguous in that in one place medical ethics is a subdivision of professional ethics and elsewhere it includes clinical and research ethics. I do not think that the two classifications are mutually exclusive but their relationship should have been explained better. When he states, however, that the manual claims ''that one cannot do medical ethics in the true sense of that word, if one does not accept certain traditional values'', I have to ask him to clarify one word, ''do'', and one phrase, ''in the true sense of that word''. For my purposes, the former is the more important. Thinking about and teaching are two ways of ''doing'' medical ethics, but the manual focuses on a different meaning of ''doing'', namely, implementation of the duties and responsibilities of physicians vis à vis patients, society, colleagues, research subjects, etc.

This distinction between the different meanings of ''doing'' medical ethics leads directly into Søren Holm's discussion of the role of oaths. He raises important points about the prevalence, nature, and ongoing effects of oaths that do call into question my description of medical ethics. However, in so far as taking an oath is simply an outward sign of something more fundamental, namely, initiation into a profession with explicit duties toward others, as formulated in codes of ethics and enforceable by regulatory bodies, the absence of an oath taking ceremony does not negate the fundamental character of medical ethics as something specific to physicians.

Per Nortvedt offers two principal criticisms of the manual.[2] The first has to do with its treatment of relationships between physicians and other healthcare professionals. I must correct one misunderstanding: where the manual states that physicians are expected to exemplify the virtues of compassion, competence, and autonomy to a higher degree than members of many other professions, these ''many other professions'' do not include other healthcare professions. Again, the list of individuals and organisations to which physicians are accountable is not exhaustive. However, any physician accountability to other healthcare professionals would be of quite a different nature from their accountabilities to patients, employers, licensing authorities, etc. Finally, I am sorry that the discussion of the relationship between physicians and other healthcare professionals in chapter four comes across as all too dismissive. The manual intended to achieve just the opposite effect—to redress the negative aspects of the relationship that prevailed in the past and are still widespread today.

Per Nortvedt's second criticism relates to the manual's classification and description of ethical decision making, especially the distinction between rational and non-rational approaches. I suspect that we are in agreement on the substantive points raised here and that the apparent differences arise from imprecise terminology. Per Nortvedt uses the term ''irrational'' twice whereas the manual states explicitly that non-rational does not mean irrational. That said, I would be the first to agree that the manual needs to be supplemented with other resources in medical ethics, such as those mentioned in Appendix B.

Daniel Fu-Chang Tsai has given a very good summary of the manual's contents.[3] His main criticism touches what was

perhaps the most difficult section of the manual to formulate—that is, the different theories of bioethics. I resisted the temptation to omit all references to this topic because I felt that readers should have some awareness of the theories. But what then? I perhaps rashly suggested that a combination of the four approaches mentioned is the best way to make ethical decisions rationally, and I gave a simple logarithm to illustrate how this can be done. This is where Daniel Fu-Chang Tsai takes issue. First of all, he states: ''Deontology and consequentialism are two anti-theses which are theoretically contradictory to and incompatible with each other''. Perhaps this is true when they are considered as grand theories and defended by ethical fundamentalists. As he goes on to point out, however, principlism aims to overcome this chasm. If it is successful, then it would seem that at the practical level deontology and consequentialism are not entirely incompatible. Daniel Fu-Chang Tsai is also correct to say that virtue ethics is not particularly helpful for making ethical decisions. It is more valuable for implementing such decisions. Perhaps, then, it would have been more precise to say something like ''principlism, which is a combination of deontology and consequentialism, is the best way to make moral decisions rationally, and virtue ethics is important for implementing such decisions''. More precise, but rather awkward.

Daniel Fu-Chang Tsai also criticises the manual's description of public health. Perhaps this is one instance, and there are undoubtedly many others, where the situation differs markedly from one country to another. The relationship between the rights of individuals and those of the community is not the same worldwide, and this results in a variable emphasis on the ethical acceptability of specific public heath measures. Moreover, in some countries, public health physicians have a different view of their responsibilities from other physicians. The manual attempted to emphasise the responsibility of all physicians for public health while noting that cultural differences need to be taken into account.

In conclusion, I am grateful to the three reviewers for their careful consideration of, and responses to, the manual and I am greatly relieved that they did not find it fundamentally flawed. Although it is always difficult, if not impossible, to measure the impact of a project such as this, it is evident that the manual has been widely accessed since its launch in January 2005 and that it will reach many more readers when the translations now under way are completed. The reviewers' generally positive evaluations can reassure these readers that the manual is a basically sound introduction to medical ethics.

Competing interests: I am the author of the *World Medical Association Medical Ethics Manual*.

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